Kentucky Board of Medical Licensure
310 Whittington Parkway,#1B
Louisville, KY 40222
502/429-7150
www.kbml.ky.gov

M E M O R A N D U M

TO: Physician Requesting Supervising Physician Privileges

FROM: Sandy K. Brooks, Physician Assistant Coordinator

RE: Application to Supervise a Physician Assistant

Attached is an initial application to supervise a physician assistant in the Commonwealth of Kentucky as well as a supplemental application to supervise a physician assistant. The supplemental application is required to request additional scope of medical services and procedures not acquired through an approved physician assistant training program.

Please note that only completed applications will be considered by the Kentucky Board of Medical Licensure's Physician Assistant Advisory Committee. Incomplete applications will be returned to the applicant. The fee for approval to supervise a physician assistant is $100.00.

The Committee meets quarterly to review applications and make recommendations to the Kentucky Board of Medical Licensure for final approval. Should you wish to begin employing the physician assistant prior to the Board meeting, there are provisions for temporary certification for supervising the new physician assistant applicant and, tentative approval for supervising the certified physician assistant**.** Please note that temporary certification or tentative approval must be granted prior to the physician assistant providing services under your supervision. The review process for approval takes approximately two to three weeks. The deadline for consideration of an application for the Physician Assistant Advisory Committee is listed below:

Deadline Dates	**Committee Dates**	**Board Meeting Dates**
January 13, 2006	February 2, 2006	March 16, 2006
April 14, 2006	May 4, 2006	June 22, 2006
July 14, 2006	August 3, 2006	September 13, 2006
October 13, 2006	November 2, 2006	December 14, 2006

Should you have any questions regarding the above, please contact me at (502) 429-7150.

Definitions of Levels of Supervision

It is necessary to indicate on the application the level(s) by which you will be supervising a physician assistant.

Direct Supervision: This means the supervising physician is actually in sight of the physician assistant when the physician assistant is performing the function requiring direct supervision. Although the physician may be performing some other task at the time, the supervising physician may immediately provide direction or assume the performance of the task if difficulties arise. This does not require that the physician is watching "over the shoulder" of the physician assistant as would be required during the training period to ensure that the physician assistant is competent to perform the task.

On-site supervision: Requires the physical presence of the supervising physician in the same location (i.e. the physician's office suite) as the physician assistant, but does not require the physical presence in the same room.

Off-site supervision: The supervising physician must be continuously available for direct communication with the physician assistant and must be in a location that, under normal conditions, is not more than 30 minutes travel time from the physician assistant's location.

*****The Board has adopted as policy that a physician assistant be required to have two continuous years of experience before the Board approves off-site supervision. Direct or on-site supervision will be required at all times during a physician assistant's first two years of practice unless a waiver has been requested by a supervising physician and approved by the Board. A primary or alternate supervising physician will have to be, at a minimum, on-site during a physician assistant's work shift during this two-year period.

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Initial Application for Physician to Supervise Physician Assistant
"This Application is in Compliance with the American Disabilities Act"

1. Name of Supervising Physician: _____
(First) (Middle) (Last)

2. Office Address: _____
(Street Address)

_____
(City) (State) (Zipcode)

3. Telephone: (Office) _____ 4. Type of Practice: _____

5. Kentucky Medical License Number: _____ Expiration Date: _____

6. Professional background including membership in medical societies, American Boards, Board eligibility, and or other professional organizations:

_____

_____

7. List hospital staff positions: _____

_____

8. Have you filed application to supervise a physician assistant before? If your answer is YES, list the names of the physician assistants on whom applications to supervise have been previously submitted. ☐ Yes ☐ No

_____

_____

9. The names and address of one or more physicians who will serve as a supervisor for the physician assistant named in this application in the temporary absence of the supervising physician. Pursuant to 311.854, Sec 2[c], enclose a copy of the alternate agreement to supervise.

Name Address KY License Number Specialty

_____

_____

_____

10. Name of physician assistant: KY Certification Number: _____

_____
(First) (Middle) (Last)

11. Briefly describe the nature of your medical practice: _____

_____

_____

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12. Briefly describe the physician assistant job duties and scope of medical services and procedures that are being delegated by you and that are also within the physician assistants scope of practice acquired in their approved training program. *(To request additional scope of medical services and procedures not acquired through an approved training program, please submit the **supplemental application form**.)* _____

    _____

    _____

    _____

    _____

13. Check all levels of supervision that apply: ☐ **Direct Supervision** ☐ **On-Site Supervision** ☐ **Off- Site Supervision**
    (See attachment for definitions of levels of supervision.) *A physician assistant shall not practice medicine or osteopathy in a separate location from the supervising physician unless the physician assistant has two continuous years of experience in a non-separate location. The Board may modify or waive the requirement.*

14. Will the physician assistant be employed full-time or part-time? _____
    If part-time, please give an estimate of how many hours. _____

15. Describe the means by which you will maintain a line of communication with the physician assistant when not at the same location: _____

    _____

16. List all locations of your practice in which the physician assistant will be utilized: (Include all offices, clinics, hospitals, nursing homes, etc.) Use a separate sheet, if necessary:

    _____

    _____

17. I maintain a practice primarily within the State of Kentucky: ☐ Yes ☐ No

18. Is the physician assistant currently employed by another supervising physician? If your answer is YES, list names of all other supervising physicians and the approximate hours the physician assistant works with that supervising physician.

    _____

19. Is your Kentucky medical license current and in good standing with the KY Board of Medical Licensure? ☐ Yes ☐ No

20. **I Attest That**:

    A. All job duties and scope of medical services and procedures delegated to the physician assistant are within my scope of practice.

    B. All job duties and scope of medical services and procedures delegated to the physician assistant are appropriate for which the physician assistant has been trained in an approved training program.

    C. I accept responsibility for any care given by the named physician assistant.

    D. I maintain a system to assure that the physician assistant is not practicing beyond the scope of my practice.

    E. I will sign all records rendered by named physician assistant in a timely manner as certification that the physician assistant performed the services as delegated.

F. I will re-evaluate the reliability, accountability, and professional knowledge of named physician assistant two years after the physician assistant's original certification in the state of Kentucky, and every two years thereafter; and based on the re-evaluation recommend or disapprove re-certification to the Board.

G. I will notify the Board within three business days if I cease to supervise or employ the named physician assistant.

Affidavit of Applicant

I, _____ hereby state that I have made an adequate investigation and am of the opinion that the aforementioned physician assistant is possessed of good moral character and is both mentally and physically able to perform as a physician assistant with competence. I further state that as supervising physician, I will exercise control and supervision of the named physician assistant in accordance with the rules of the Kentucky Board of Medical Licensure and retain professional responsibility for the care and treatment of patients he/she sees as directed by me.

State of Kentucky County _____

I, _____ hereby certify under oath that I am the person named in this application to supervise a physician assistant in the Commonwealth of Kentucky; that all statements I have made therein are true and the physician assistant will function under my supervision and responsibility.

_____
Physician's Signature

Subscribed and sworn to before me by the above named applicant on this _____ day of _____,20____.
This application consists of 3 pages.

Seal of Notary

_____
Signature of Notary

My Commission expires:_____

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Alternate Supervising Physician Agreement

RE: _____ _____
Name of Physician Assistant Name of Primary Supervising Physician

In Compliance with Kentucky State Statute 311.854 Section 2 (c), I agree to serve as an alternate supervising physician for the above mentioned physician assistant in connection with patients under my care. I further understand that this regulation stipulates I can only supervise two physician assistants at one time. **(The alternate supervising physician, must be a physician other than the primary supervising physician.)**

Physician (s) Name	License Number	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I 've read the above, and agree that these physicians will be alternate supervising physicians in my absence.

_____
Signature of Primary Supervising Physician

Sworn to and subscribed before me by the above name applicant on this _____ day of _____ 20 ___.

_____
Notary

My Commission Expires _____.

FAXES WILL NOT BE ACCEPTED

Revised 6/13/05

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Supplemental Application Scope of Practice of Physician Assistant

1. Name of Supervising Physician: _____
   (First) (Middle) (Last)

2. Kentucky License Number:_____ Expiration Date: _____

3. Office Address: _____

   _____

4. Telephone (Office) _____ Office Fax _____

5. Name of Physician Assistant _____ KY Certification Number_____

6. Describe the physician assistant's additional scope of medical services and procedures not described in the initial application or previously submitted supplemental applications that are being delegated by you. _____

   _____

   _____

   _____

7. Describe the training and education that prepared the physician assistant for this additional delegated scope of medical services and procedures requested. (Information submitted for an accredited facility regarding this scope of practice can be submitted to fulfill this item.) _____

   _____

   _____

   _____

8. Was this training on-the-job training? ☐ Yes ☐ No

9. Was this education accredited? ☐ Yes ☐ No

10. Describe the setting in which the physician assistant will practice this additional delegated scope of medical services and procedures _____

    _____

    _____

11. Describe the level of supervision for this additional delegated scope of medical services and procedures (direct supervision, on-site supervision, off-site supervision) _____

    _____

12. Has this additional delegated scope of medical services and procedures been approved by an accredited facility duly constituted medical staff? ☐ Yes ☐ No

13. Has this additional delegated scope of medical services and procedures received the blessing of your specialty society for delegation to a physician assistant? ☐ Yes ☐ No

14. **I attest that:**

    A. All additional delegated scope of medical services and procedures are within my scope of practice.

    B. All additional delegated scope of medical services and procedures are appropriate to the physician assistant's education, training and level of competence.

    C. I accept responsibility for any care given by the named physician assistant.

Affidavit of Applicant

I, _____ hereby state that I have made an adequate investigation and am of the opinion that the aforementioned physician assistant is possessed of good moral character and is both mentally and physically able to perform as a physician assistant with competence. I further state that as supervising physician, I will exercise control and supervision of the named physician assistant in accordance with the rules of the Kentucky Board of Medical Licensure and retain professional responsibility for the care and treatment of patients he/she sees as directed by me.

State of Kentucky County_____

I, _____ hereby certify under oath that I am the person named in this application to supervise a physician assistant in the Commonwealth of Kentucky; that all statements I have made therein are true and the physician assistant will function under my supervision and responsibility.

_____
Physician's Signature

Subscribed and sworn to before me by the above named applicant on this _____ day _____,20____.
This application consists of 2 pages.

Seal of Notary

_____
Signature of Notary

My Commission expires:_____